MDR Tracking Number: M5-04-1459-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution –General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 1-23-04.

The IRO reviewed office visits, physical therapy services and durable medical equipment, (DME) rendered from 8-18-03 through 11-1803 that were denied based upon "V".

The IRO concluded that all office visits (99211, 99212, 99214) are approved; all manual therapy procedures (97140) are approved; a maximum of 4 units of therapeutic exercise (97110) per patient encounter are approved; the miscellaneous durable medical equipment (E1399) is approved. All remaining services through the specified date range are denied.

The Medical Review Division has reviewed the IRO decision. The IRO has not clearly determined the prevailing party over the medical necessity issues. Therefore, in accordance with §133.308(q)(2)(C), the commission shall determine the allowable fees for the health care in dispute, and the party who prevailed as to the majority of the fees for the disputed health care is the prevailing party.

DOS	CPT CODE	Billed	MAR$ (Maximum Allowable Reimbursement)	Medically Necessary	Not Medically Necessary
8-18-03 8-22-03	99211-25	$30.00	$18.00	$18.00	
8-18-03 8-19-03 8-22-03 8-26-03 8-28-03 8-29-03 9-2-03 9-3-03 9-4-03 9-5-03 9-22-03 9-23-03 9-26-03 9-30-03 10-1-03 10-2-03 10-6-03 10-13-03 10-14-03 10-16-03	G0283	$20.00	Per EOB this is electric stimulation, per requestor with a MAR of $15.00. This code is not part of MFG		$15.00 X 20 dates = $300.00
8-18-03 8-19-03	97140	$100.00	Per EOB this is manual therapy per requestor with	$96.00 X 20 dates =	

8-22-03 8-26-03 8-28-03 8-29-03 9-2-03 9-3-03 9-4-03 9-5-03 9-22-03 9-23-03 9-26-03 9-30-03 10-1-03 10-2-03 10-6-03 10-13-03 10-14-03 10-16-03			a MAR of $96.00. This code is not part of MFG	$1920.00	
8-18-03 9-30-03 10-2-03 10-6-03 10-16-03	97110 (4)	$180.00	$35.00 / 15 min X 4 = $140.00	$140.00 X 5 dates = $700.00	
8-19-03 8-22-03 8-26-03 9-3-03 9-5-03 10-13-03 10-14-03	97110 (5)	$225.00	$35.00 / 15 min X 5 = $175.00	$140.00 Per IRO only 4 units are MN X 7 dates = $980.00.	
8-28-03 8-29-03 9-2-03 9-4-03 10-1-03	97110 (6)	$270.00	$35.00 / 15 min X 6 = $210.00	$140.00 Per IRO only 4 units are MN X 5 dates = $700.00	
8-18-03 8-26-03 10-13-03	97530	$40.00	$35.00 / 15 min		$35.00 X 3 dates = $105.00
8-19-03 11-18-03	99212-25	$45.00	$32.00	$32.00 X 2 dates = $64.00	
8-19-03 8-22-03 8-28-03 9-2-03 9-3-03	97010	$15.00	$11.00		$11.00 X 5 dates = $55.00
8-19-03	E1399G	$16.00	DOP	$16.00	
8-29-03 9-22-03 9-26-03 10-6-03	97124	$45.00	$35.00/ 15 min		$35.00 X 4 dates = $140.00
9-5-03	99080-73	$15.00	$15.00		$15.00
9-22-03	99214-25	$105.00	$71.00	$71.00	
TOTAL				$4469.00	$615.00

On this basis, the total amount recommended for reimbursement ($4469.00) represents a majority of the medical fees of the disputed healthcare and therefore, the requestor prevailed in the IRO decision. Therefore, upon receipt of this Order and in accordance with **§133.308(r)(9)**, the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $460.00** for the paid IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On March 30, 2004, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Maximum Allowable Reimbursement)	Reference	Rationale
9-5-03	99080-73	$15.00	$0.00	V, F	$15.00	Rule 129.5(d)	TWCC-73 was not submitted to challenge carrier's position that was not appropriate. Since IRO found report not to be MN, no reimbursement is recommended.

This Decision is hereby issued this 19th day of August 2004.

Elizabeth Pickle
Medical Dispute Resolution Officer
Medical Review Division

ORDER.

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay ($4469.00 + $460.00 refund IRO fee) for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Decision is applicable for dates of service 8-18-03 through 11-18-03 in this dispute.

This Order is hereby issued this 19th day of August 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

NOTICE OF INDEPENDENT REVIEW DETERMINATION
REVISED 3/25/04

MDR Tracking Number: M5-04-1459-01
IRO Certificate Number: 5259

March 12, 2004

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

___ hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to ___.

Sincerely,

CLINICAL HISTORY
Patient was a 74-year-old female patient who, on ___, picked up a bag of clothes to put on top of a clothes bin when she experienced pain in her right shoulder. She eventually underwent acromioplasty on 10/16/02, post-operative therapy where she continued in pain and disability, and underwent a second surgery on 05/21/03 that included rotator cuff repair and A-C joint debridement. She then participated in an aggressive post-operative physical therapy program.

REQUESTED SERVICE(S)
Office visits, minimal (99211), office visits, problem focused (99212), office visits, reevaluation (99214), electrical stimulation, unattended (G0283), manual therapy (97140), therapeutic activities (97110), hot/cold pack therapy (97010), miscellaneous durable medical equipment (E1399), and massage therapy service (97124) for dates of service 08/18/03 through 11/18/03.

DECISION
All office visits (99211, 99212, 99214) are approved; all manual therapy procedures (97140) are approved; a maximum of 4 units of therapeutic exercise (97110) per patient encounter are approved; the miscellaneous durable medical equipment (E1399) is approved.

All remaining services through the specified date range are denied.

RATIONALE/BASIS FOR DECISION

The medical records and diagnosis submitted in this case well established the medical necessity for periodic evaluation and monitoring on the part of the treating doctor, so the office visits were certainly reasonable. Also, given the documented range of motion restriction, manual therapy was also deemed medically necessary. Although E1399 is an unspecific HCPCS code, it is determined from the records to represent Biofreeze gel that was dispensed to the patient, and this, too, was reasonable and medically necessary. And because of the multiple surgeries, the patient's age, and the physical performance tests that were done substantiating the medical necessity for therapeutic exercise, a total of 4 units (for one hour) per patient encounter was also appropriate. However, for a shoulder injury, it was not medically necessary to exceed 4 units of exercise in this case, particularly when the record clearly demonstrated that the patient was dispensed both a home pulley system as well as a Theraband tube with which to exercise at home.

Insofar as the hot/cold pack therapy (97010) was concerned, the record repeatedly stated, "Her treatment was concluded utilizing myofascial therapy over the right shoulder muscles followed by interferential and hot packs to decrease myofascial pain, inflammation, and spasm." This modality is therefore denied if reducing inflammation was the goal.

Relative to the HCPCS code G0283, this modality is denied as not medically necessary because the dates in question were 2 months post-operative, and – absent a documented flare up – the use of this passive modality cannot be supported.

Finally, massage therapy services (97124) are denied as medically unnecessary because they are duplicative. They are a component of ”manual therapy”, or 97140, that was also performed and reported on the same dates of service.